

**OUTSTANDING AMBULANCE SERVICE
AWARD NOMINATION FORM***

Please mail this form to EMS Awards, Community Health and EMS Section, P.O. Box 110616, Juneau, AK 99811-0616 or fax it to EMS Awards, (907) 465-4101 **so that it is received by Tuesday, September 12, 2000.**

Name and Title of Person Submitting Nomination: _____

Telephone number of Person Submitting
Nomination: _____ (Work) _____ (Home)

Name of Ambulance Service Organization Nominated: _____

Location: _____

Name of Chief or EMS Captain: _____

Service Level Provided: BLS _____ Certified? _____
ALS _____ Certified? _____

Number of Paid Personnel: EMT-I ____, EMT-II ____, EMT-III ____, EMT-P ____
ETT ____, R.N. ____, OTHER _____

Total Paid Personnel: _____

Number of Volunteer Personnel: EMT-I ____, EMT-II ____, EMT-III ____, EMT-P ____
ETT ____, R.N. ____, OTHER _____

Total Volunteer Personnel: _____

How long has this service been organized? _____

History: _____

Continuing Education Program during past year:

**In 500 words or less: Why should this ambulance service organization be considered outstanding?
How does it perform over and above the basic level of service provided by all ambulance services?**